IDAHO STATE BOARD OF MEDICINE

THE REPORT

THE REPORT SPRING 2009

PAIN MANAGEMENT OVERVIEW

By Ralph M. Sutherlin, DO, Idaho State Board of Medicine

The Joint Commission has published guidelines regarding pain management in which they speak of "patients' rights to pain relief" and encourage adding pain level as "the fifth vital sign." All physicians need to be sensitive to pain as an issue in the treatment of all conditions and diseases, and to take patient pain reports seriously. "Quality patient care must include appropriate and effective pain relief." Effective pain management lowers morbidity and reduces costs. The patient who doesn't have to spend energy fighting pain has more energy to recover and heal.

Pain should be assessed and treated promptly, effectively and for as long as pain persists. Once all clinical evaluations and procedures have been carried out, formulate a pain treatment plan tailored to that specific patient's needs. Monitor the patient's progress and adjust the plan to achieve maximum patient comfort and maximum patient function. The medical management of pain should be based on up-to-date knowledge about pain, pain assessment and pain treatment. Pain treatment may involve the use of several medications and non-pharmacological treatment modalities, often in combination. For some types of pain, the use of medications is emphasized and should be pursued vigorously; for other types, the use of medications is better de-emphasized in favor of other therapeutic modalities. Physicians and surgeons should have sufficient knowledge or utilize consultations to make such judgments for their patients. Medications, in particular opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures, or cancer.

Addiction should be placed into proper perspective. Physical dependence and tolerance are normal physiologic consequences of extended opioid therapy and are not the same as addiction. Addiction is a behavioral syndrome characterized by psychological dependence and aberrant drug related behaviors. Addicts compulsively use drugs for nonmedical purposes despite harmful effects; a person who is addicted may also be physically dependent or tolerant. Patients with chronic pain should not be considered addicts or habitués merely because they are being treated with opioids.

Inappropriate prescribing of controlled substances, including opioids, can lead to drug abuse or diversion and can also lead to ineffective management of pain, unnecessary suffering of patients, and increased health costs. In short, the assessment and effective management of pain is a patient right that should be preserved but the support of illicit drug use for whatever purpose should not be facilitated under the guise of pain management. There are a handful of naïve, and an even smaller number of corrupt, physicians who have paid dearly for not recognizing that difference. Like most issues in medicine, there are several grey areas and it is hoped that with adequate clinical experience, sound educational knowledge and good common sense, most of these pitfalls may be avoided most of the time.

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NOTICE This newsletter is the only information newsletter published by the Idaho Board of Medicine and serves as the Board's notification of rule changes, policy information, and discipline information provided to all licensees of the Idaho Board of Medicine.

Pain Management Overview (continued)

The Federation of State Medical Boards has published its *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*, in which it states that it is recognized "that principles of quality medical practice dictate that (patients) have access to appropriate and effective pain relief," and that "the appropriate application of up-to-date knowledge and treatment (of pain) can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain." It urges that "all physicians should become knowledgeable about effective methods of pain treatment as well as statutory requirements for prescribing controlled substances."

The details of the Federation's guidelines can be summarized as follows:

- A thorough patient work-up;
- A sound diagnosis, based on the work-up;
- A treatment plan;
- An adequate follow-up to assess patient response;
- Any necessary adjustments to the treatment plan;
- Complete documentation of patient care.

The Joint Commission's guidelines parallel the Federations' very closely. Both organizations' guidelines are intended to be used in the management of all types of pain, acute and chronic:

- Acute Pain
  - Acute pathological pain
  - Acute post trauma pain
  - Acute post op pain
- Chronic Pain
  - Chronic malignant pain
  - Chronic benign pain

While the treatment plans and methods for each of these types of pain may vary, the clinical analysis which leads to a treatment plan does not vary. Physicians and surgeons may use control of pain, increase in function, and improved quality of life as criteria to evaluate the treatment plan.

A written consent or pain agreement for chronic use is not required but may make it easier for the physician and surgeon to document patient education, the treatment plan, and the informed consent. Patient, guardian, and caregiver attitudes about medicines may influence the patient's use of medications for relief from pain.

Complete documentation is not only important for the practitioner's own use in managing the pain case, but is also an essential element in the practitioner's ability to properly demonstrate that thorough assessment, work-up and planning have gone into the case's management. Indeed, complete documentation is the best resource available to the physician when it is necessary to argue on behalf of the patient's best interest in obtaining payment coverage. Also when any external party reviews a physician's work, the most important element in reconstructing his or her patient care is documentation. The Board has found that inadequate documentation is a feature of nearly all complaint reviews which lead to investigations or discipline.

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Pain Management Overview (continued)

Patients with pain who are managed with controlled substances should be seen monthly, quarterly, or semiannually as required by the standard of care.

Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. Complex pain problems may require consultation with a pain medicine specialist.

In addition, physicians should give special attention to those pain patients who are at risk for misusing their medications including those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse requires extra care, monitoring, documentation and consultation with addiction medicine specialists, and may entail the use of agreements between the provider and the patient that specify the rules for medication use and consequences for misuse.

Physicians and surgeons who prescribe opioids either for acute or persistent pain should not fear disciplinary or other action from law enforcement or regulatory agencies for the mere fact of having prescribed opioids. Don't fear discipline from medical boards or criminal prosecution if you follow pain guidelines and appropriately prescribe medications. The Medical Board expects physicians and surgeons to follow the standard of care in managing pain patients.

Three studies concerning medical boards, prosecution and pain-treatment guidelines are published in the Spring 2003 issue of the peer-reviewed *Journal of Law, Medicine & Ethic*s. A survey of 38 medical boards found boards were abandoning drug quantity as a marker of questionable practice and assessing instead whether a doctor properly evaluated a patient and followed the board's pain-treatment guidelines. A second study of county prosecutors in Oregon, Maryland, Washington and Connecticut found the likelihood of investigation or prosecution "extremely low." A third study said more boards had adopted pain-management guidelines but recommended that they take greater steps to train investigators about pain standards and circulate guidelines to physicians.

We recommend that physicians go back to the basics of the practice of medicine in order to achieve appropriate pain management, and scrupulously adhere to each of the steps of the clinical process.

Board welcomes new members:

William Cone, MD, to the Board of Medicine

William Ganz, MD, to the Board of Medicine

Barry Bennett, MD, to the Board of Medicine

And bid farewell….

The Board expressed their appreciation to Michael Melendez, MD, for his service to the Board from 2003-2009 as a member of the Idaho Board of Medicine, and to Stephen Marano, MD, for his service to the Board from 2003-2007 as a member and from 2007-2009 as Chairman of the Board of Medicine

BOARD ACTIONS

PLEASE NOTE

Some physicians have similar names, please verify information by license number on our web site at: www.bom.state.id.us

Annual statistical report in this newsletter

Raymond Hooft, MD

M-5477 Meridian, ID

Board Action: Motion for Enforcement withdrawn. Hearing vacated.

Thomas Richards, MD

M-10565 Moscow, ID

Board Action: Termination of Stipulation and Order

Explanation of terms:

- Stipulation: an agreement, admission, or concession.
- Stipulation and Order: an agreement between the Board and the practitioner regarding authorization to practice or placing terms or conditions on the authorization to practice.
- Suspension: temporary withdrawal of authorization to practice.
- Reprimand: a formal admonishment of conduct or practice.
- Revocation: cancellation of the authorization to practice.

Christopher Sundquist, PA

PA-333 Coeur D Alene, ID

Allegation: Failure to meet standard of care, narcotics

Board Action: Amended Complaint

License Fees

The Idaho Board of Medicine is approaching 11 years without a license fee increase for initial licensure or renewal. Amazing in these tough economic times, and even more amazing is that you can thank yourself, your staff, the hospital staff, and all of the others who are using the on line renewal system and on line services the Board offers. Thanks to your participation and willingness to use these systems you have enabled the Board to move on to another year without a fee increase, however if you are one of the individuals that fails to renew on time, by June 30 of the expiration year, you will be seeing a fee increase for some professions. The Board acted to increase fees first for those individuals who fail to renew in a timely manner because they incur an additional expense in processing and mailing correspondence, staff time in processing late renewals, and the extension of time for the employment of temporary employees to process renewals and perform associated financial duties.

Follow Up

By Steven Snow, Executive Director Council for the Deaf and Hard of Hearing

The Board of Medicine received a few inquiries regarding the article by Steven Snow printed in last month's newsletter. Mr. Snow has provided additional information and responses to the inquiries.

Does the ADA define business in regards to number of employees? Is a doctor with a staff of two (himself and assistant) required to provide interpreters for not only the hearing impaired but anyone with a communication issue (language, hearing, speech etc.)

Title I under ADA refers to reasonable accommodations for employees who are disabled. Under that title, it clearly outlines a business with more than 15 employees are required to provide reasonable accommodations for employees only. Employer with less than 15 employees is not required to provide accommodation for a disabled employee (unless they receive federal money). However- under Title III (Public Accommodation) regardless of a number of employees, (be it one, two or hundred) an employer or a business is required to provide reasonable accommodations for clients, patients, or customers who are disabled. To best determine what kind of accommodations, the providers should communicate with the patients or clients on their needs.

I believe doctors are not required by law to provide interpreters or accommodation for ***non-disabled*** individuals such as Spanish speaking patients.

Is there a national certification for interpreters for sign language? If there is no national certifying agency, how can the quality and identification of valid interpreters be evaluated?

Yes, there is a national certification for sign language (American Sign Language) interpreters. Its website is: http://www.rid.org/. ADA doesn't require businesses to use certified interpreters- HOWEVER it states that the interpreter must be qualified. In most cases, qualified interpreters normally hold certifications. Unfortunately some of the interpreters might claim they are qualified but they really aren't. The best practice would be to use certified interpreters.

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
DISCIPLINE SUMMARY										
Lic. Revkd/surrndrd/suspend	8	1	7	4	5	8	10	9	3	6
Lic. Denied/Wthld/Wthdrn	2	0	1	0	2	3	3	3	4	5
Lic. Rstrct/Lmtd	19	12	11	12	16	4	6	3	9	12
Rehab-Alc/drgs	6	3	4	5	5	2	2	6	1	8
Hearings, Intrvws	2	2/4	3/5	1/4	1/5	4/2	7/7	3/7	1/6	2/4
Investigations	113	140	142	173	161	184	251	296	254	233
Complaints							340	390	363	330
Rprmnd/Admntns	23	14	13	23	26	19	21	26	32	27

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
PRELIT. SCREENING										
Hearing Requests	122	156	178	158	140	110	119	104	102	120
Number of Defendents	191	304	348	269	242	196	204	178	175	231
Hearings Completed			117	221	126	123	114	102	109	103
Findings										
With Merit	17	14	23	31	30	33	19	26	27	19
Without Merit	69	81	79	165	92	69	78	54	62	60
Some/Posible Merit	8	15	15	25	4	6	6	0	7	7
Claims Wdrwn/dsmsd/stld	14	17	20	32	13	15	11	22	13	9

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
PHYSICIANS - MD											
New Licenses Issued	255	248	238	264	321	250	227	267	307	352	415
Licenses Renewed	2926	3104	3038	3205	3125	3267	3359	3343	3435	3620	3842
Active	3181	3210	3218	3296	3446	3517	3586	3610	3742	3807	4257
Inactive	160	151	156	173	201	213	238	232	202	187	169
PHYSICIANS - DO											
New Licenses Issued	17	20	18	24	29	20	27	28	47	39	51
Licenses Renewed	146	164	181	177	189	205	216	231	254	295	316
Active	163	180	193	193	218	225	243	259	301	324	367
Inactive	5	5	6	8	8	11	14	17	13	10	9
PHYSICIAN - VOLUNTEER											
New Licenses Issued								1	2	0	1
Licenses Renewed									1	3	3
Active									3	3	4
PHYSICIAN ASSISTANTS											
New Licenses Issued	33	27	53	45	41	51	44	61	60	75	57
Licenses Renewed	116	134	159	175	216	239	270	307	354	402	447
SUPERVISING PHYSICIANS											
New Registrations Issued	64	84	83	73	71	64	13	95	72	113	62
Registrations Renewed	169	199	171	275	258	251	286	244	314	368	322
SUPERVISING PHYSICIANS COSMETIC & LASER											
New Registrations Issued										14	9
Registrations Renewed											14

ATHLETIC TRAINERS											
New Licenses Issued	17	10	14	11	14	28	18	20	25	22	25
Licenses Renewed	92	99	99	118	112	115	121	125	128	128	134
DIRECTING PHYSICIANS											
New Registrations Issued							27	14	4	8	3
Registrations Renewed								27	38	38	23
OCCUPATIONAL THERAPY											
Therapists -New Licenses Issued	48	24	39	51	33	23	44	45	48	40	49
Licenses Renewed	251	255	257	255	287	306	310	328	349	380	400
Assistants - New Licenses Issued	28	12	20	25	6	5	12	5	6	8	15
Licenses Renewed	55	64	69	73	97	97	96	105	102	106	110
RESPIRATORY THERAPISTS											
New Licenses Issued	77	57	53	67	73	63	46	58	69	76	53
Licenses Renewed	462	495	483	470	498	528	553	570	578	610	651
POLYSOMNOGRAPHY											
Technician - New Permits Issued							22	0	9	10	15
Permits Renewed								16	8	13	11
Technologist - New Permits Issued							21	2	8	10	11
Permits Renewed								21	21	29	36
DIETITIANS											
New Licenses Issued	25	33	19	33	23	24	17	31	40	33	29
Licenses Renewed	253	255	276	280	295	327	307	302	314	344	356

LICENSE RENEWAL

License renewal time is here if your license expires in 2009. For instructions and information on the on-line renewal process please see the Board of Medicine web site at www.bom.state.id.us. Please note that there is an additional five dollar charge for processing a paper renewal this year.

Allied Health Board Notes

The Board of Occupational Therapists has moved to the Bureau of Occupational Licenses.

The Physician Assistants will seek legislative changes to allow ownership of medical practices in 2010.

Again, licensing boards are seeing applicants that engage in unlicensed practice. If you responsible for supervising or hiring employees, please verify license status on our web site. The risk to the public, the cost to agencies and the impact of unreimbursed service are just a few the adverse effects of unlicensed practice.

Calendar of Board of Medicine Meetings for 2009

June 12, 2009
September 11, 2009
December 4, 2009 **

** Meeting scheduled for Board Office

DEPLOYED?

IF YOU ARE DEPLOYED PLEASE PROVIDE A COPY OF YOUR MILITARY ORDERS FOR DEPLOYMENT AND A COPY OF THE ORDERS RETURNING TO THE U.S. OR RELIEVING YOU FROM ACTIVE DUTY WHEN YOU RETURN. UPON RECEIPT OF THE ORDERS THE BOARD WILL MAINTAIN YOUR LICENSE IN ACTIVE, CURRENT STATUS WHILE DEPLOYED AND WAIVE ALL LICENSE FEES FOR UP TO 6 MONTHS AFTER YOUR RETURN.

IDAHO STATE BOARD OF MEDICINE

David McClusky, II, MD, Chairman

Trudy Jackson, Public Member

Leo Harf, MD, Member

Laura McGeorge, MD, Member

Joyce McRoberts, Public Member

Jerry Russell, Director, Idaho State Police

Ralph Sutherlin, DO, Member

William Cone, MD, Member

William Ganz, MD, Member

Barry Bennett, MD, Member

COMMITTEE ON PROFESSIONAL DISCIPLINE

Mike Johnson, Public Member, Chairman

A.C. Jones, III, MD, Member

Julia Bouchard, MD, Member

Bruce Miewald, MD, Member

Wendell Wells, MD, Member

Allied Health Board Meetings

Meetings are held in the Board office unless otherwise noted.

The Board of Athletic Trainers meeting to be announced.

The Dietetic Licensure Board meeting is scheduled for October 13, 2009 at 11:00 a.m.

The Respiratory Therapy Licensure Board meeting is scheduled for October 15, 2009 at 9:30 a.m.

The Physician Assistant Advisory Committee meeting is scheduled for October 30, 2009 at 9:00 a.m.

Please note if you are submitting a response to a Board inquiry or a completed application, the completed material must be received in the Board office at least 20 days before the scheduled meeting date. Materials not received in that time frame will be added to the next regularly scheduled meeting agenda.

BOARD STAFF

Nancy Kerr, Executive Director

Mary Leonard, Associate Director

Cathleen Morgan, Board Attorney

Beverly Kendrick, Quality Assurance Specialist

Cynthia Michalik, Quality Assurance Specialist

Janet Whelan, Quality Assurance Specialist

Gloria Pedersen, Prelitigation Manager

Darlene Parrott, Compliance Monitor

Terri Solt, Physician Licensing Manager

Jodi Adcock, Allied Health Licensing Manager

Mary McCulley, Finance

Jennifer Winn, PA Licensing–Prelitigation

Stephen Tyrer, Investigative Assistant

IDAHO STATE BOARD OF MEDICINE

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VISIT OUR WEB SITE AT
www.bom.state.id.us

FAIR AND IMPARTIAL APPLICATION AND ENFORCEMENT OF THE PRACTICE ACTS

CHANGE OF ADDRESS EACH YEAR OF NUMBER OF LICENSE RENEWAL APPLICATIONS GO ASTRAY BECAUSE THE ADDRESS ON FILE WITH THE BOARD IS INCORRECT. AS A RESULT, LICENSES PEOPLE WISH TO MAINTAIN ARE CANCELLED AND HAVE TO BE REINSTATED. PLEASE COMPLETE AND RETURN THIS FORM IF YOUR ADDRESS CHANGES.

ID License No._____

Name_____

(LAST) (FIRST) (MIDDLE INITIAL)

Former Address: _____

(STREET)

_____

(CITY) (STATE) (ZIP)

New Address:

_____

(STREET)

_____

(CITY) (STATE) (ZIP)

Phone (_____)_____Date change becomes effective: _____

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